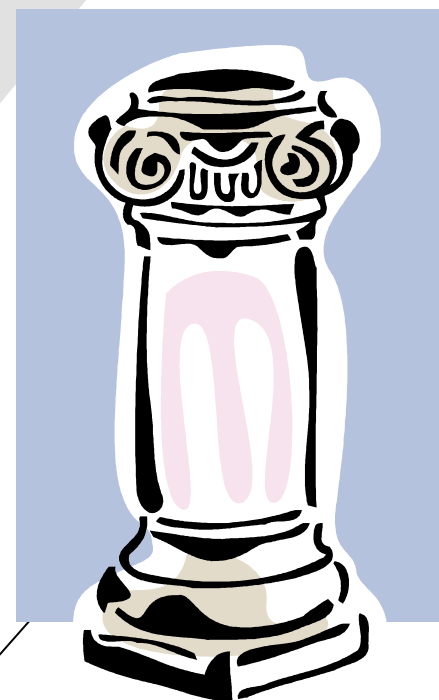
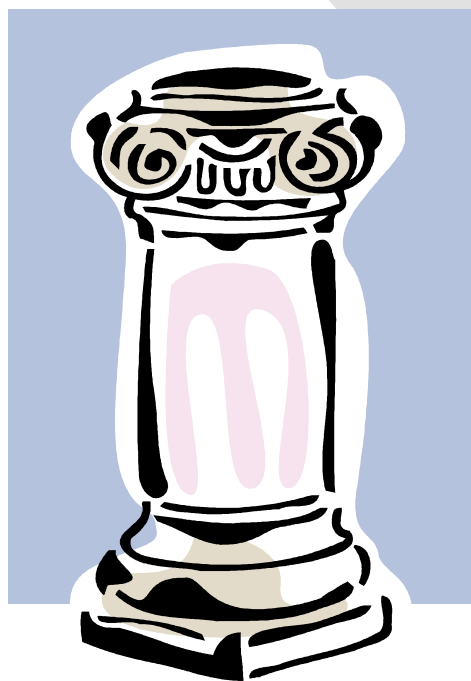
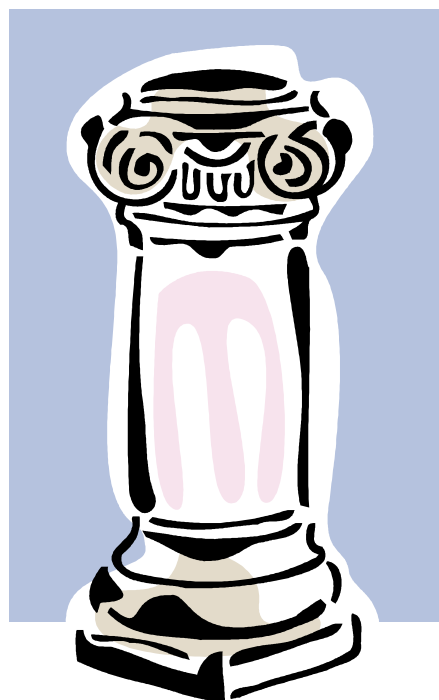


# Understanding the Pillars of the HCBS Waiver

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R. Cooper, NASDDDS 4/14



With thanks to Dena Stoner for the cartoon...

# Gary Smith said...

- Medicaid, it's not rocket science....



It's harder..!!!



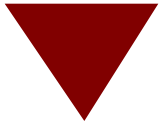
# We'll cover



- Key Home and Community Based Services (HCBS) waiver regulatory requirements
- Key HCBS waiver concepts
- The waiver application

***This is just an overview—every one of just the waiver application appendices could be a day-long presentation...***

We will take time for questions at the end



# What is Medicaid?

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(Just to make sure we're all on the same page...)

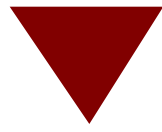
- Medicaid is a state/federal program begun in 1965 and originally intended to provide health and medical services to low income individuals
- Medicaid is a \$450 billion program nationally and is a central source of funding for long term supports and services for individuals with disabilities and seniors

# ▼ What *is* a HCBS Waiver??

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- A waiver means that the regular rules are “waived”, that is not applied
- The HCBS waiver began in 1981 as a means to correct the “institutional bias” of Medicaid funding
- The “bias” is that individuals could get Medicaid financed services while institutionalized, but if they wanted to return to the community they could not Medicaid financed home and community-based services





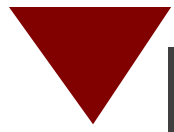
# What *is* a HCBS Waiver??

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- Section 1915 (c) of the Social Security Act was changed to allow states to ask for waivers of existing Medicaid regulation
- The idea is that states can use the Medicaid money for community services that would have been used if the person went to an institution
- Thus, **getting HCBS waiver services is tied to institutional eligibility**

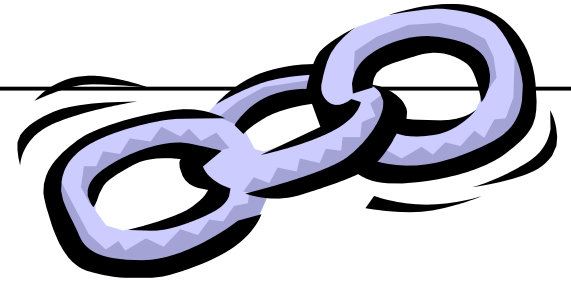






# Institution/HBCS link

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- This does NOT mean you have to go to an institution or want to go to an institution—just that you ***could*** be ***eligible*** for services in an institution
- The waiver means you can choose services in the community

# ▼ Why bother with Medicaid waivers?

Like Willie Sutton said when asked why he robbed banks.... *“It’s where the money is.”*



Medicaid is a matching program where state pays part of the cost (based on a formula) and the feds “match” what the state pays...this is important because the availability of state money drives how many people the waiver can serve and how much a state spends..

# State/federal partnership

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- The Centers for Medicare and Medicaid Services (CMS) provides states with an application to fill out (called the waiver format or template)
- The state fills in the template and submits the plan to CMS
- Because the waiver is a Medicaid program, the Single State Medicaid Agency must submit the application and provide oversight to the waiver, but another agency can operate the waiver day-to-day



# State/federal partnership



## **RESOURCES YOU MUST HAVE:**

Application for a §1915 (c) HCBS Waiver, HCBS Waiver Application, Version 3.5

**AND**

Application for a §1915(c) Home and Community-Based Waiver [Version 3.5] , Instructions, Technical Guide and Review Criteria,  
Release Date: January 2008

Found at: <https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp>

# State/federal partnership

- CMS reviews and approves the application(sometimes after considerable negotiation)
- HCBS Waivers are approved for a three year period initially and can be renewed for five-year periods





## Who can a HCBS waiver serve?

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- The person must be eligible for Medicaid, according to your state rules, and
- Meet what's called the level of care (LOC) for nursing home, ICF-IID, hospital or other Medicaid-financed institutional care
- \*ICF-IID: Intermediate care facility for individuals with intellectual disabilities



## Level of Care (LOC)

- LOC means that the person has needs that *could* make them eligible for institutional care “but for the provision of HCBS services”
- The person (or parent or guardian) also must be offered the option of institutional care --even if there's no way they'd ever want it—because if eligible under Medicaid people have the right to choose an institution instead of the community

# Time out....

**States Without Public or  
Private Facilities/Institutions  
(>16 beds) include:**

Alabama  
Alaska  
District of Columbia  
Hawaii  
Maine  
Rhode Island  
New Hampshire  
New Mexico  
Oregon  
Vermont

- Since people who are eligible can choose ICF-IIDD services, does this mean states have to have ICFs-IID?
- No. If for some reason an individual demands an ICF-IID the state can provide it by offering ICF-IID services in another state and contracting out for those services.



# Waivers and Entitlement



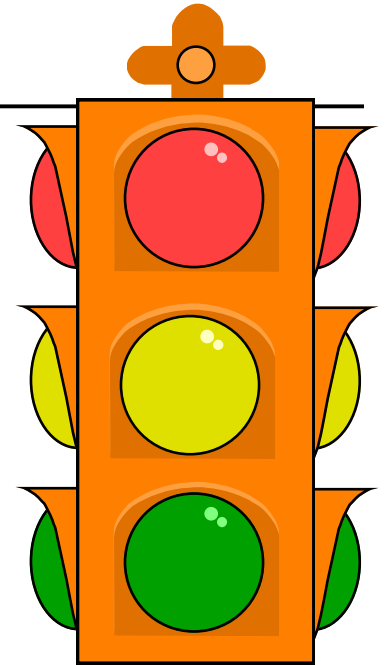
- Medicaid services under the Medicaid State plan are an entitlement, that is, if a person has “medical necessity” for the service, the person is entitled to the service-no waiting lists are allowed
- HCBS waivers are not quite the same since states can “target” specific groups, set enrollment priorities *and* cap the total number of people served
- Individuals have an “entitlement” to a waiver only if they meet the target group and other eligibility AND the state has vacancies in the program
- The state can have waiting lists for HCBS waivers



# Waiver cans and can'ts

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- Okay, it is a federal program and there are *some* rules...so let's first take a look at what you **can't** do, so we know what we **can** do with a waiver...



# ▼ Waiver can'ts

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■ HCBS waivers are federal programs and there are *some* rules...so you:

Can't give cash directly to a waiver participant or parent...(but consumer-directed and controlled services are perfectly permissible)

Can't pay for room and board with Medicaid money (except for respite, nutritional supplements, or one meal/day-like Meals on Wheels or as a part of live-in caregiver option)

# ▼ Waiver can'ts...



- Can't pay for exactly the same stuff under the waiver that is covered by the Medicaid state plan until you first use those services
  - Can provide for “extended State plan services” for adults\*, again once Medicaid card services are used up
  - Can “redefine” services so they aren’t quite the same as State plan services and then cover them under a waiver
- Can’t do general home repair with waiver dollars-but you can repair housing accessibility modifications

\* *BUT...must cover Medicaid card services for all kids*

# ▼ Waiver can'ts...



- Can't pay for services that are otherwise covered under the Rehabilitation Act or Individuals with Disabilities Education Act...that is services that a vocational rehabilitation agency are required to cover or services that are part of the public education system's responsibility to deliver.
- Can't cover vocational services, which are services that teach job task specific skills required by a participant for the *primary purpose of completing those tasks for a specific facility based job and are not delivered in an integrated work setting through supported employment.*

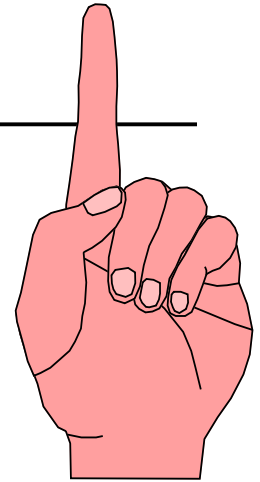
# Waiver can'ts



- Can't cover a few services such as recreation\*\*, guardianship or institutional services other than respite
- Can't serve folks who don't meet the Medicaid eligibility rules your state got approved under their waiver

\*\*but “therapeutic” recreation and assistance to participate in recreational activities are okay...

## ▼ And there are requirements...

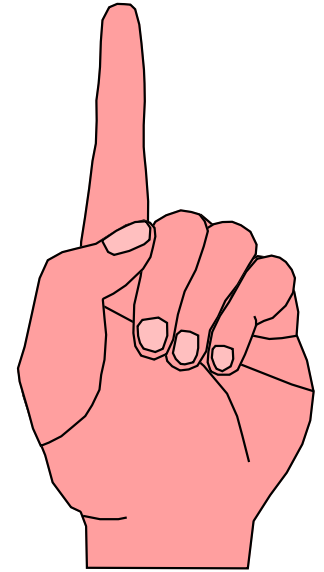


These are things the state **MUST** do.  
The state must promise the feds  
that the waiver:

- is cost-neutral. This means the *average* cost per person under the waiver can't be more than the *average* cost per person in an ICF-DD.

**Community \$ < or = Institution \$**  
(Individual costs can vary widely)

# And there are "havetas"...



- Everyone has an individual plan of care developed by qualified individuals
- Must have provider standards, designed by the state and approved by CMS, that make sure the people giving support know what they are doing
- Necessary safeguards have been taken to protect the health and welfare



# More things the state **MUST** do:

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- Freedom of choice of providers. This means people can choose any provider they want that is qualified, under state rules, to do the work.

Portability of funding. Medicaid money “follows the person”, i.e. the benefit “belongs” to the individual, not the provider.

- Informed choice of institutional or community-based services.



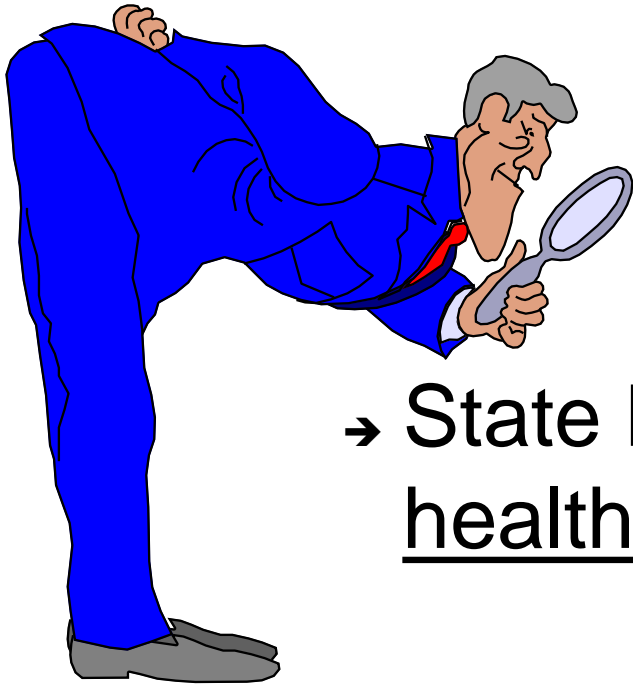
# More things the state **MUST** do:

- Financial accountability for all funds. This means the state has to know how the money is spent, for what people and what services.





# More things the state **MUST** do:



- State has a formal system to monitor health and safety.



# Monitoring health and safety includes:

- State oversight of the service system and providers through visits to counties, consumers and providers
- Collecting CMS required data on system performance and waiver assurances
- Getting information from waiver participants about their experiences
- A formal system to prevent, report and resolve instances of abuse or neglect



## More things the state **MUST** do:

- Operate the waiver statewide unless the state has special permission to only have the waiver in some areas or operate it differently in different localities
- Make sure everyone on the waiver can generally get the same types of services all over the state—called access to service





## More things the state **MUST** do:

- Make sure that people with the same type of needs get the same amount of money to spend on services—called equity of services

# More things the state **MUST** do:

## HCB Settings

- Have to make sure that all settings where people live and spend their days meet the new Home and Community-Based (HCB) settings rules published on March 17, 2014
- More on this in a minute...
- Web site for information:  
[www.cms.gov/hcbs](http://www.cms.gov/hcbs)



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## And the biggest "haveta" of all..

- States **MUST** do what they said they were going to do in the waiver application approved.. (but that doesn't mean the waiver can't be changed as things change)





# HOME AND COMMUNITY BASED (HCB) SETTINGS RULES

- HCB Settings Character
  - What is NOT community
  - What is likely not community
  - What is community



# BEFORE WE DEFINE HCB SETTINGS CHARACTER..



- Settings that are NOT Home and Community-based:
  - Nursing facility
  - Institution for mental diseases (IMD)
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
  - Hospital

# Settings PRESUMED NOT to Be Home And Community-based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

# BUT....



- The rules give the Secretary of HHS the discretion to ascertain if certain settings meet the HCB settings character
- That means that with regard to the settings described on the previous slide, states may make the case that the setting(s) *does* meet HCB settings character

# WHICH BRINGS US TO HCB SETTINGS CHARACTER



- The home and community-based setting requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences
- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting\*
- The new standards are “**experiential**” and about “**qualities**” of the setting



\*Echoes of Olmstead?



# HCBS SETTING REQUIREMENTS



42CFR441.310(C)(4)

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

# HCB SETTING REQUIREMENTS

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

# CONGREGATE SETTINGS AND THE HCB SETTINGS REQUIREMENTS

- **Be aware this is not just residential...the HCBS settings requirements apply to ALL HCB settings including day programs....**
- CMS noted in the comments...:
  - “To the extent that the services described are provided under 1915(i) or 1915(k) (for example, residential, day, or other), they must be delivered in settings that meet the HCB setting requirements as set forth in this rule. We will provide further guidance regarding applying the regulations to non-residential HCB settings.”



## AND CMS SAID

- *Application of setting requirements to non-residential settings* – Rule applies to all settings where HCBS are delivered, **not just to residential settings** and CMS will provide additional information about how states should apply the standards to non-residential settings
- So this is also about where people spend their days...

# TRANSITION PLANNING

- Transition planning-coming into compliance with the HCB settings requirements
  - States have until March 17, 2015 to file a plan to come into compliance
  - All new programs must be in compliance
  - Have 5 years to complete the transition to all settings meeting the new rules

# Although the waiver has rules, within those rules it's up to the state and stakeholders to decide:

- the values that underlie your system
- whom you want to serve and how many people you serve
- the processes used to develop individual support plans
- what supports & services you cover
- who can provide those services
- what you pay for the services, and
- how health, safety and quality are determined





# Acronyms

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**CMS:** Centers for Medicaid and Medicare Services

**HCBS:** Home and community-based services

**ICF-IID:** Intermediate Care Facility for Individuals with Intellectual Disabilities

**LOC:** Level of care

**Medicaid:** Same as MA, Medical Assistance

**POC:** Plan of care

**QMS:** Quality Management Strategy

# Contact Information

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